Reece Center for Handicapped Horsemanship
Medical History/Physician Release

Rider Name: _____DATE:_____

D.O.B__/__/__AGE:___Sex:_____Height:_____Weight:_____Pulse:_____B.P.:_____

Diagnosis:_____

Cause:_____

Medications (Type, Purpose, Dose):_____

_____

If Downs Syndrome, Atlanto-Axial Subluxation? Yes___ No___

Cervical X-Ray for Atlanto-Axial Subluxation: Positive___ Negative___ X-Ray Date:___/___/___

Tetnus Shot: Yes___ No___ Date:___/___/___

Please indicate if the client has or has a history of the following secondary problems by checking "Yes" or "No". If YES please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF "YES" OR "HISTORY OF" PLEASE DESCRIBE
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses:
Allergies			
Cardiac			

PROBLEM	YES	NO	IF "YES" OR "HISTORY OF" PLEASE DESCRIBE
Circulatory			
PVD			
postural hypotension			
hemophilia			
Pulmonary			
Asthma/COPD			
Muscular			
contractures			
Neurological			
seizures/controlled			**Type:**
last seizure:__/__/__			
hydrocephalus			
shunt			
sensory loss			
pain			